Supreme Court, U.S.
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No. 93-510

In The
Supreme Court Of The United States
October Term, 1993

AETNA LIFE INSURANCE COMPANY and
AETNA HEALTH MANAGEMENT,
Petitioners,

v.

STUART CIRCLE HOSPITAL CORPORATION,
Respondent.

ON PETITION FOR WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

BRIEF *AMICUS CURIAE*
IN SUPPORT OF PETITIONER

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Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

MOTION OF CIGNA CORPORATION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

Pursuant to Rule 37.2 of the Rules of this Court, *amicus*, CIGNA Corporation ("CIGNA") hereby moves for leave to file the attached brief *amicus curiae*. Petitioners have granted but respondent has refused to grant consent for CIGNA to file a brief *amicus curiae* in support of the petition.

CIGNA, through its subsidiaries, operates the largest investor-owned managed care organization in the United States. Based on CIGNA's experience, managed care provides a viable means of restraining rapidly increasing health care costs through marketplace competition, while assuring quality of care. The Fourth Circuit decision in this case is anti-managed care and anti-health care reform. It undermines the ability of insurers to offer managed care plans that can effectively control health care costs and to compete effectively with HMOs and self-insured managed care plans. By requiring insurers to include any willing providers in preferred provider arrangements, marketplace competition, consumer choice and access to care are all adversely affected.

CIGNA believes that it is in a position to bring to this Court's attention relevant matters that could not be brought fully to the Court's attention by petitioner and that respondent is unlikely to bring to the Court's attention. CIGNA therefore respectfully requests leave to file the attached brief *amicus curiae*.

October, 1993

Respectfully submitted,

/s/ Josephine A.Marchetti
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BRIEF *AMICUS CURIAE* IN SUPPORT OF PETITIONER

Pursuant to Rule 37.2 of the Rules of this Court, *amicus*, CIGNA Corporation ("CIGNA") hereby submits the following brief *amicus curiae*.

INTEREST OF CIGNA CORPORATION

CIGNA, through its subsidiaries, operates the largest investor-owned managed care organization in the United States with 2,616,714 participants in its various health maintenance organizations ("HMOs") and preferred provider

arrangements ("PPOs") nationwide. In Virginia, CIGNA has more than 130,000 participants in its HMOs and PPOs.

Managed care is the centerpiece of the health care reform plan proposed by the President of the United States, as well as the other key reform proposals pending before Congress. CIGNA is deeply committed to managed care as a means of controlling health care costs. Managed care controls health care costs by integrating both the financing and delivery of health care services through: (1) selective contracting with a limited number of providers who will furnish services to participants at a discounted rate; (2) ongoing quality assurance and utilization management programs; and (3) financial incentives for participants to utilize the selectively contracted providers. By undermining the ability to selectively contract and thereby control costs, "any willing provider" laws, such as that found in Va. Code Ann. §38.2-3407 (1993), have a profoundly negative impact on managed care organizations such as CIGNA.

ARGUMENT

PPOs and HMOs have developed in response to the demand from employers and consumers to control rising health care costs associated with traditional fee-for-service ("indemnity") plans. These managed care programs have been successful in reducing costs for both employers (lower premiums) and consumers (lower co-payments, deductibles and premium contributions), making more generous plan coverage possible. Based on CIGNA's internal data, the annual premium cost for indemnity plans is 20-60% more than that of managed care plans utilizing selectively contracted provider networks. In addition, the benefit package under managed care plans is typically 10-15% richer

than that of indemnity plans, resulting in better health care coverage for consumers at lower out-of-pocket costs.

The key to the success of managed care programs is the ability to limit, through selective contracting, the number of providers to the level required to meet the needs of the enrolled population. The ability to selectively contract with providers results in lower costs for several reasons: (1) providers' willingness to negotiate discounts off the cost of their services is dependent upon the patient volume that the managed care plan can deliver; (2) administration costs are lower if there are fewer providers to deal with; and (3) utilization costs are lower because only the most efficient providers are included and it is easier to monitor utilization of a smaller number of providers.

Selective provider contracting also facilitates efforts by managed care organizations to assure the quality of care. It is easier to monitor treatment patterns, conduct provider education, enforce practice protocols and utilization review standards, perform credentialing functions and monitor member satisfaction with a smaller number of providers that share the managed care organization's objectives in assuring quality of care.

In 1991, the Wyatt Company ("Wyatt") was commissioned by the Health Insurance Association of America to study and estimate the costs associated with six legislative mandates, including mandates that "any willing provider" be allowed to join a managed care network. In its report entitled *Cost Analysis of State Legislative Mandates on Six Managed Health Care Practices* (June 7, 1991), Wyatt concluded that increasing provider panel size impairs the ability of a PPO to reduce costs even to the point where there

are no cost savings at all (*see* pp. 5, 14, 23). In addition, "the 'any willing provider' mandate makes it extremely difficult for a PPO to limit provider participation while still making the criteria flexible enough to attract the right providers" in terms of quality and demographic spread (*see* p. 23).

Although the Virginia General Assembly appears to recognize the value of insured PPOs by its enactment of §38.2-3407, the "any willing provider" provision of this statute, which applies only to insurers, negates the ability of insurers to provide quality care and effectively manage costs through preferred provider arrangements. Insurers are, thus, unfairly denied the opportunity to compete on a level playing field with HMOs and self-insured plans which are not subject to this provision and free to selectively contract with providers. Denying insurers the opportunity to compete effectively with HMOs and self-insured plans also results in fewer choices for consumers. In addition, it has the adverse effect of encouraging the development of self-insured managed care arrangements which are beyond the pale of insurance regulation. As a consequence, consumers lose the protection of such regulation, including mandated benefits and solvency protection.

"Any willing provider" laws also have the socially undesirable effect of encouraging providers to continue practicing in highly saturated areas rather than practicing in areas with medically underserved populations. If managed care organizations can, through selective contracting, limit their networks to the number of providers actually needed to serve their participants, some providers will be encouraged to establish practices in underserved areas. By encouraging providers to practice in already overserved areas, "any willing

provider" laws do a disservice to consumers in medically underserved areas. In addition, overutilization of services is more probable in overserved areas.

SUMMARY OF ARGUMENT

The "any willing provider" mandate in Virginia's PPO statute is anti-competitive and anti-consumer. Although it appears on its surface to protect consumer choice, it actually reduces consumer choice by precluding insured PPOs from competing in the health care marketplace. It also has the effect of promoting unregulated, self-insured managed care arrangements and discouraging the distribution of health care providers to medically underserved areas.

CONCLUSION

For the foregoing reasons, CIGNA respectfully requests the Court to grant the Petition for Writ of Certiorari of Aetna Life Insurance Company and Aetna Health Management and set the case for plenary review.

October, 1993

Respectfully submitted,

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